Bob Taft
Governor

Tom Hayes
Director

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December 4, 2003

Cheryl A. Harris
Associate Regional Administrator
Region V
Centers for Medicare and Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Ms. Harris:

The Ohio Department of Job and Family Services (ODJFS) is forwarding responses to the November 25, 2003 Centers for Medicare & Medicaid Services (CMS) request for further information pertaining to our PremierCare waiver amendment request.

Section D: Cost Effectiveness

1. Please describe the State's enrollment assumptions regarding children, adults, and pregnant women used to develop the composite rate for the Medicaid population.

   ODJFS Response: Ohio does not expect significant variation in the distribution of future enrollment compared to past enrollment for populations covered by the waiver. The base year composite rate was developed based on actual enrollment in the base period. Our actuary, Mercer Government Human Services Consulting assumed that the enrollment distribution would remain stable and did not adjust this distribution for future periods.

2. Please certify that when and if any of the one percent at-risk amounts are collected from the plans, the Federal share of the amounts collected will be immediately returned on the quarterly CMS-64 expenditure reports. The Federal share may then be reclaimed at the time any performance incentive payments are actually made from the dedicated account.

   ODJFS Response: As ODJFS Bureau of Federal Financial Reporting staff recently discussed with Don Clifton, CMS Regional Office staff stationed in Ohio, if and when collected from the plans, the one percent at-risk amounts will be immediately returned on the quarterly CMS-64 expenditure report. The amounts will be reported on the same line that we report the regular MCO payments on, specifically, line 18A on the CMS

64.9 waiver form for PremierCare. If and when received from the plans, the one-percent at-risk amounts are deposited in an Ohio fund named 4Z1, Reporting Category 4570, using SAC 6MC5. The Bureau of Federal Financial Reporting will certify on an on-going basis that the federal share of these funds have been returned to CMS. The federal share will be reclaimed at the time a performance incentive payment is made to a plan.

Standard Funding Questions

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the Managed Care Organizations (MCOs) in the PremierCare waiver retain 100 percent of the payments. Do the MCOs retain all of the Medicaid capitation payments? Do the entities participate in such activities as intergovernmental transfers (IGT) or certified public expenditure (CPE) payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the MCOs are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

ODJFS Response: The MCOs retain the Medicaid capitation payment (except for a small "at-risk" portion which is retained contingent on meeting certain performance standards as described below). The MCOs do not participate in activities such as intergovernmental transfers or certified public expenditure payments. No portion is returned to any local government entity or to any other intermediary organization, and to the State only under conditions related to performance (see below).

As described in the Capitation Rate Final Certification letter from Mercer Government Human Services Consulting, as well as in the approved 1915(b) PremierCare waiver in Section D.H.d., the managed care capitation rate includes a 1% at-risk portion paid to the MCOs each month. This amount is retained in whole or in part by the MCO if a certain performance level is achieved. If the specified level is not met by an MCO, there may be a return to the State of some or all of the at-risk amount. If any amount is returned, it is deposited in a dedicated account used solely to provide additional incentive payments to those plans performing at a superior level. Please refer to Appendix L of the federally-approved managed care plan contract for detailed information on performance expectations and the process. As of this date, no performance incentive payments have been made.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid capitation payment for the MCOs is funded. Please describe whether the State share is from appropriations from the legislature, through IGTs, CPEs, provider taxes, or any other mechanism used by the State to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payment. If any of the State share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the State verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

   ODJFS Response: The State share of the Medicaid capitation payments is funded by Ohio's General Revenue fund. All funds (state and federal) paid are appropriated by the Ohio General Assembly in the State's biennial budget. Estimates of expenditures for PremierCare are provided in detail in the PremierCare waiver, Appendix D, as approved, and as submitted in the pending waiver amendment.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the MCOs.

   ODJFS Response: This is also addressed in the waiver in Section D.H.d. At this time, no incentive payments (the only type of enhanced or supplemental payment considered in the PremierCare program) have been made. The estimate used for Program Year One of the waiver was that payments of $500,000 could potentially be made under the performance incentive program. This equates to $0.09 PMPM. The amount is trended forward for Program Year 2. These amounts are also reflected in Appendix D of the waiver application and amendment.

4. Payments Under Risk Contracts Financial Question. Are there any actual or potential payments to MCOs, pre-paid inpatient health plans, pre-paid ambulatory health plans, or other providers under this waiver which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as disproportionate share hospitals, academic medical centers, or federally qualified health centers.) If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

   ODJFS Response: No actual or potential payments under the waiver exceed the amount certified as actuarially sound. The capitation rates were set assuming that each MCO would retain the 1% at–risk portion. Even if an MCO received an incentive payment, the total would be well within the 105% maximum permitted by federal regulations. Please see Section D.H.d. of the PremierCare waiver for more detailed information.

If managed care contracts include mechanisms such as risk corridors, does the State recoup appropriate amount of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports?

ODJFS Response: This is not applicable to PremierCare; the managed care contracts do not have risk corridors.

5. 1915(b)(3) financial question. Does any provider receive payments (normal per diem, diagnostic related group, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

ODJFS Response: We believe that this question, as a 1915(b)(3) question, is unrelated to Ohio's PremierCare program. No additional 1915(b)(3) services are provided.

We understand that another 90-day review clock will start at day one as soon as CMS receives our response. However, as you know we have worked with CMS informally to address the questions being raised and would greatly appreciate an expedited review. If there are additional comments regarding the enclosed responses, please contact me, either by telephone (614.466.4693) or e-mail (burnec@odjfs.state.oh.us).

As always, thank you for your continued support and assistance.

Sincerely,

Cynthia Burnell, Chief
Bureau of Managed Health Care

Enclosure

c: Mike Fiore, CMS Baltimore
Claudia Lamm, CMS Baltimore
Gwen Sampson, CMS RO
Cynthia Garraway, CMS RO
Barbara Coulter Edwards, Deputy Director, Office of Ohio Health Plans